Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INTEGRA MEDICAL GROUP
8108 FOX CREEK TRAIL
DALLAS TX 75249

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-2053-01

MFDR Date Received
FEBRUARY 24, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pre-authorized - #8396859. Per MAR Fee Guidelines/No contract."

Amount in Dispute: $230.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier determined that the treatment should be reimbursed at $51.20 and $359.20, respectively. The carrier submits that all fee reductions were made in accordance with the applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 19, 2010	Work Hardening – CPT Code 97546-WH (x2)	$51.20	$51.20
March 29, 2010	Functional Capacity Testing - CPT Code 97750-FC (x12)	$179.60	$179.56
TOTAL		$230.80	$230.76

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 Texas Register 626, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.

4. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W1-Workers compensation state fee schedule adjustment.
   - 45-Charges exceed your contracted/legislated fee arrangement.
   - 19-Precertification/authorization exceeded.
   - 15-The authorization number is missing, invalid, or does not apply to the billed services or provider.

Issues

1. Does the submitted documentation support that a contractual agreement issue exists in this dispute?
2. Does a preauthorization issue exist in this dispute?
3. Is the requestor entitled to additional reimbursement for CPT code 97546-WH?
4. Is the requestor entitled to additional reimbursement for CPT code 97750-FC?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges Exceed Your Contracted/Legislated Fee Arrangement." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. According to the explanation of benefits, the respondent denied reimbursement for CPT code 97546-WH based upon reason code "19."

   28 Texas Administrative Code §134.600(l) states "The carrier shall not withdraw a preauthorization or concurrent review approval once issued. The approval shall include:

   (1) the specific health care;
   (2) the approved number of health care treatments and specific period of time to complete the treatments; and
   (3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury."

   On February 25, 2010, the respondent's representative preauthorized a work hardening program five times a week for two weeks for a total of 80 hours.

   A review of the submitted documentation finds that the progress note indicates that claimant arrived at work hardening at 8:00 a.m. and left at 12:00 p.m. for a total of four hours. The respondent paid for three hours.

   The respondent did not submit any documentation to support that the requestor exceeded the preauthorization approval; therefore, this denial is not supported.

3. 28 Texas Administrative Code §134.204(h) states "The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier.
   (1) Accreditation by the CARF is recommended, but not required.
   (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   28 Texas Administrative Code §134.204(h) (3) states "For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.
   (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.
   (B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97545-WH and 97546-WH for four (4) hours on the disputed dates of service. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (3)(A) and (B), the MAR is 80% of $64.00/hour = $51.20 x four (4) hours = $204.80. The carrier paid $153.60. Therefore, the difference between the MAR and amount paid is $51.20. This amount is recommended for reimbursement.

4. 28 Texas Administrative Code §134.204 (g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test."

The requestor billed for 12 15 minute units = four (4) hours of CPT code 97750-FC.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2010 DWC conversion factor for this service is 54.32.

The Medicare Conversion Factor is 36.0791

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75050, which is located in Dallas County.

The Medicare participating amount for code 75050 in Dallas County is $29.82.

Using the above formula, the MAR is $538.76.

The respondent paid $359.20. The requestor is due $179.56 additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $230.76.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $230.76 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	7/8/2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.